MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

11452

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: no
How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Lake St
(If rural, give LOCATION)
2.(a) If veteran, name war: World War No I

3. (a) FULL NAME Frank Adkins

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	A.A.	Married

8.(b) Name of husband or wife: Erma Adkins
6.(c) If alive, give age: Don't Know years
7. Birth date of deceased (mo., day, yr.): Yes about 1892

8. AGE: Years	Months	Days	If less than one day
about 53			...hrs. ...min.

8. Birthplace: Parsonsburg md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: no Same as above
FATHER 12. Name: John Adkins
13. Birthplace: Parsonsburg md
MOTHER 14. Maiden name: Belle Shockley
15. Birthplace: Parsonsburg Md
18. Informant: Mrs Reed walker
Address: Salisbury md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 3 - 1945 (month) (day) (year)
Cemetery or crematory: Glen Hill
Location: Parsonsburg md
18. Funeral director: James A Stewart
Address: Salisbury md
19. 11/3 1945. Received by registrar: Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1, 1945, at 6 30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 1, 1945, to Nov. 1, 1945 and that I last saw h. alive on Sept 1, 1945

Immediate cause of death	DURATION
Acute Myocarditis	10 min
Due to: Bronchial Asthma	3 mos
Due to:	
Other conditions: Hypertension	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G H Lembly MD M. D. or other
Address: Salisbury Md Date signed: 11/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

CERTIFICATE OF DEATH

11453

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Hrs.

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 3 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Baby Baine

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 27 1945

8. AGE: Years	Months	Days	If less than one day
0	0	0	14 hrs. ..... min.

9. Birthplace: Snow Hill Worcester Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Lonsie Baine

FATHER — 13. Birthplace: Snow Hill Md

MOTHER — 14. Maiden name: Ella Melborne

MOTHER — 15. Birthplace: Snow Hill Md

16. Informant: Lonsie Baine

Address: Snow Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-29-1945 (month) (day) (year)

Cemetery or crematory: Mt Wesley Comm

Location: Snow Hill Rual

18. Funeral director: Heans & Dennis

Address: Snow Hill md.

19. 11/29/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1945 at 12 Midn.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27 1945 to Nov. 27 1945 and that I last saw him alive on Nov. 27 1945

	DURATION
Immediate cause of death: Prematurity	1 day
Due to:	
Due to:	
Other conditions	

(Include pregnency within 3 months of death)

Major findiegs of operatioes

Date of op.

Autopsy results

PHYSICIAN: Please underliee the cause to which death shoeld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, tarm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert L. LeMar, MD M. D. or other

Address: Snow Hill. Date signed 11/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

11454

Reg. Dist. No. 330

1. PLACE OF DEATH: Wiconico

County

City or town: Mardela

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution or street address where death occurred: at Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wiconico

City or town: Mardela

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Edward Bennett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rosie J. Bennett

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb. 14 - 1872

8. AGE: Years: 73 | Months: 9 | Days: 5 | If less than one day: ...hrs. ...min.

9. Birthplace: R.D. Mardela Md.
(Town, county and state)

10. Usual occupation: Retired

11. Industry or business: School Teacher

FATHER — 12. Name: William Wiley Bennett

FATHER — 13. Birthplace: R.D. Mardela Md.

MOTHER — 14. Maiden name: Elizabeth A. Riggin

MOTHER — 15. Birthplace: R.D. Mardela Md.

16. Informant: Mrs Rosie J. Bennett

Address: R.D. Mardela, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 22-45 (month) (day) (year)

Cemetery or crematory: Mardela Cem.

Location: Mardela Md.

19. Funeral Director: Holloway & Walter R. Holloway

Address: Salisbury Md.

19. 11/22/45 19... W. H. Robertson
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19th 1945 at 6-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on ... 19...

Immediate cause of death: Coronary Thrombosis — DURATION: Sudden death

Due to:

Due to:

Other conditions: Chronic myocarditis — DURATION: 6 mos

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: La Rodemeyer M.D. or other

Address: Salisbury, Md. Date signed 11/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

11455

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, institution, or street address where death occurred: P. G. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Wilmore Brittingham

3.(b) Social Security Number: 216-10-3262

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If olivo, give age: years

7. Birth date of deceased (mo., day, yr.): June 20 1902

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
43	5			

9. Birthplace: Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: Timber Woods
FATHER 12. Name: William Brittingham
13. Birthplace: Maryland
MOTHER 14. Maiden name: Rebecca Stinger
15. Birthplace: Maryland
16. Informant: Mrs. John Schofield
Address: Snow Hill, Md
17. Burial, cremation, or removal. Which?: Burial Date thereof: 11 26 45 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Snow Hill, Md
18. Funeral director: Deane & Dennis
Address: Snow Hill, Md
19. (Date rec'd by registrar): 11/23/45 Registrar: Harriet E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 19 45, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 18 1945 to November 20 1945 and that I last saw h... 1m alive on November 20 1945

Immediate cause of death	DURATION
Meningitis, Pneumococcal	3 days
Due to: Pneumonia, Pneumococcal	
bilateral, lower lobe	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen, M.D. M. D. or other
Address: Snow Hill Date signed: 11/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (103)

11456

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 years
Hospital, institution, or street address where death occurred 1000 E. Church St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1000 E. Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louisa C. Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Anthony Brown
(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): July 27-1860

8. AGE: Years	Months	Days	If less than one day
85	3	20	..... hrs. ..... min.

9. Birthplace: P.O. Delmar Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: at Home
MOTHER FATHER
12. Name: Elijah Maddox
13. Birthplace: P.O. Delmar Md.
MOTHER
14. Maiden name: Nancy Burk
15. Birthplace: P.O. Delmar Md.
16. Informant: Miss Lucy J. Brown
Address: 1000 E. Church St. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19-45 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Md
18. Funeral director: Hillman & C. Walter R. Hillman
Address: Salisbury Md
19. 11/15/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17th 1945 at 1130 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw ... alive on ... 19..

Immediate cause of death	DURATION
Hemorrhage from Wound	Sudden death
Due to Unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury Injured at work?

23. SIGNATURE Jas Rademaker MD Deputy Medical Examiner
M. D. or other
Address Salisbury Md Date signed 11/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-21

CERTIFICATE OF DEATH

11457

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Prince G
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution or street address where death occurred: P.R.R. Track
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: North Hampton
City or town: Cheston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Edward Brumley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha E. Brumley
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): June 16 1906

8. AGE: Years 45 | Months 5 | Days 0 | If less than one day: hrs. min.

9. Birthplace: R.D. Delmar Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:

FATHER
12. Name: John Edward Brumley
13. Birthplace: Md.

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Mrs Martha E. Brumley
Address: Cheston Va.

17. Burial, cremation, or removal. Which? Burial Date thereof: Nov. 20-45 (month) (day) (year)
Cemetery or crematory: Fruitland Cem.
Location: Fruitland Md.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.

19. (Date rec'd by registrar) 11/20/1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1945, at M

I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Fractured Skull	Sudden death
Crushed chest	
Lacerated scalp	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11/16/45
Where did injury occur? Fruitland (City or town) Somerset (County) Md (State)
Injured at home, farm, industry, public place (where?) P.R.R. track
Means of injury Car struck by train Injured at work? No

23. SIGNATURE: J.A. Rademaker M.D.
M.D. or other
Address: Salisbury Md. Date signed 11/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

11458

CERTIFICATE OF DEATH

Reg. Dist. No. 11336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 W. State

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Calhoun

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Mrs. John Calhoun

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 31 1865

8. AGE: Years 80 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Sussex County, Del.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Winder Hearn

13. Birthplace Sussex County, Del.

MOTHER 14. Maiden name Sally Hudson

15. Birthplace Sussex County Del.

16. Informant Mrs. Louise Bacon

Address Delmar, Delaware

17. Burial, [redacted] Date thereof Nov. 4-1945
(month) (day) (year)

Cemetery or crematory Mt. Olive

Location Delmar, Delaware

18. Funeral director W. S. Hazard Co

Address Delmar, Delaware

Nov. 2 1945 Harry E. Hudson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1945 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1945, to Nov 1 1945; and that I last saw h[illegible] alive on Nov 1 1945

	DURATION
Immediate cause of death Hemorrhage of stomach	12 hrs
Due to Carcinoma of Stomach	6 mos
Due to Hypertension and arteriosclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Lynch M. D. or other

Address Delmar Del Date signed 11/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

1145

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Eden Rural 2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 84 Years

Hospital, Institution, or street address where death occurred:
At Home Eden Md. Rural 2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Eden Rural 2
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Capt. Robert J. Chatham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sallie Chatham

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1861

8. AGE: Years	Months	Days	If less than one day
84	9	14	...hrs. ...min.

9. Birthplace Wicomico Co. Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John H. Chatham

13. Birthplace Wicomico Co. Md

MOTHER 14. Maiden name Christianne Morris

15. Birthplace Wicomico, Co. Md

16. Informant Mrs Sallie Chatham

Address Eden, Md Rural 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/4/45 (month) (day) (year)

Cemetery or crematory Siloam Cemetery

Location Siloam, Md

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 11/4 (Date rec'd by registrar) 1945. [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1945 at 1030a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 1945, to Nov 2 1945

and that I last saw h... alive on Nov 1 1945

Immediate cause of death	DURATION
Chronic myocarditis	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D.
M. D. or other

Address Salisbury Md Date signed Nov 4, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DeMann

11460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1447)

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Somerset
City or town Westover (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lelia Mae Collins

3.(b) Social Security Number 219-01-8189

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	Married

6.(b) Name of husband or wife Andrew Collins
6.(c) If alive, give age 37 years
7. Birth date of deceased (mo., day, yr.) Nov. 26 1912

8. AGE: Years	Months	Days	If less than one day
32	11	18	hrs. min.

9. Birthplace Westover Somerset Co., Md. (Town, county, and state)
10. Usual occupation House worker
11. Industry or business

FATHER
12. Name John Easton
13. Birthplace Westover Somerset Co. Md.

MOTHER
14. Maiden name Fannie Collins
15. Birthplace Westover Somerset Co., Md.

16. Informant Fannie Parsons
Address Westover Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 11 1946 (month) (day) (year)
Cemetery or crematory Cottage Grove
Location Westover Md.
18. Funeral director Chas. H. Ward
Address Marion Md.
19. 11/10 1946 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1945 at 7:38 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/1 1945, to 11/8 1945
and that I last saw h alive on 1945

Immediate cause of death Acute Bright's Disease — DURATION 2 weeks
Due to Preg. nancy. — 7 mos
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos R Mann M. D. or other
Address Pocomoke Md Date signed 11/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11461

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 36 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 609 Bath
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Sarah E Collins

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a	widowed

B.(b) Name of husband or wife: Leonard Collins

Dead B.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): May 12 1881

8. AGE: Years	Months	Days	If less than one day
64	5	27	hrs. min.

9. Birthplace: allen md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

18. Informant: Mrs Beatrice Kiah

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12-1945 (month) (day) (year)

Cemetery or crematory: Hanston

Location: Salisbury md

18. Funeral director: James P Stewart

Address: Salisbury md

19. 11/12/45 (Date rec'd by registrar) Lorraine E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-9-45 1945 at 4:45 am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-5 1945, to 11-8 1945

and that I last saw h.e alive on 11-8-45 1945

Immediate cause of death	DURATION
Respiratory Paralysis	Few min
Due to General ag Debility	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. A. Purnell M. D. or other

Address: 609 W. Main St Date signed 11-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

CERTIFICATE OF DEATH

11462

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 years
Hospital, institution, or street address where death occurred: 414 Fenwood Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 414 Fenwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Martha Jane Colonna

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George N. Colonna
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Sept. 30 1851

8. AGE:

Years	Months	Days	If less than one day
94	1	4	hrs. min.

9. Birthplace: (Worcester Co.) New Hope Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: at Home
FATHER 12. Name: Samuel S. Truitt
FATHER 13. Birthplace: Worcester Co. Md.
MOTHER 14. Maiden name: Caroline Hickman
MOTHER 15. Birthplace: Worcester Co. Md.
16. Informant: Mr. Alford Colonna
Address: 402 Truitt, St. Salisbury Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 6-45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Holloway & C. Walter R. Holloway
Address: Salisbury, Maryland

19. 11/6/45 (Date rec'd by registrar) Bessie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1945, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Nov 4 1945 and that I last saw h[illegible] alive on Nov 3 1945

Immediate cause of death	DURATION
Valvular Heart Disease	10 yrs
Due to	
Due to	
Other conditions: Hypertension	Unk

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hiram R. Mann M. D. or other
Address: Salisbury Md. Date signed: 11/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11463

Reg. Dist. No. 333

1. PLACE OF DEATH

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 Years

Hospital, Institution, or street address where death occurred: 301. Barclay St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 301. Barclay St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Daniel Bidell Cordrey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife Cora E. Cordrey

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 23 - 1877

8. AGE: Years 68 | Months 9 | Days 20 | If less than one day hrs. min.

9. Birthplace R.D. Delmar Md.
(Town, county, and state)

10. Usual occupation Lumber Man

11. Industry or business at Lumber Mill

FATHER 12. Name Samuel Cordrey

13. Birthplace R.D. Delmar Md.

MOTHER 14. Maiden name Lovina A. Hitchens

15. Birthplace near Laurel, Delaware

16. Informant Mrs. Cora E. Cordrey

Address 301. Barclay St. Salisbury Md

17. Buried (Burial, cremation, or removal, Which?) Date thereof Nov. 16 45 (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Md.

18. Funeral director Hellen & Co. Walter R. Hellen

Address Salisbury Md.

19. 11/16/45 (Date rec'd by registrar) Carrie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13th 1945 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Nov. 13 1945

and that I last saw h. alive on Nov. 13 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas E. Insley M. D. or other

Address Salisbury Md Date signed 11/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-6)

CERTIFICATE OF DEATH

11464

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Years

Hospital, Institution, or street address where death occurred:

P. G. Hospital

How long in hospital or Institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No.: John B. Parsons Home (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Effie Coulbourne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: W. S. Coulbourne

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May, 18, 18--

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	6	29		

9. Birthplace: Somerset Co. Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: William Cluff

13. Birthplace: Somerset Co. Md

MOTHER — 14. Maiden name: Sussie Handly

15. Birthplace: Somerset, Co. Md

16. Informant: John B. Parsons Home

Address: Salisbury Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 11 (month) 18 (day) 45 (year)

Cemetery or crematory: Rehobeth Baptist Cemetery

Location: Rehobeth, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md.

19. (Date rec'd by registrar) 11/18/45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1945, 3.10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 17 1945 to Nov. 16 1945 and that I last saw h-r alive on Nov. 16 1945

Immediate cause of death	DURATION
Ruptured Duodenal Ulcer & Peritonitis	
Due to	
Due to	
Other conditions: Hypertensive Cardio-Vascular Disease: Myocardial Hypertrophy	

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.: —

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Rivers Hanson M.D.

M. D. or other

Address: Salisbury, Md. Date signed: 11/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

11465

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Fruitland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Twenty years
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Wicomico
City or town Fruitland (If outside city or town limits, write RURAL and give nearest town)
Street No. no (If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME Ethel Culley
3.(b) Social Security Number 222-01-8329

4. Sex female
5. Color or race c-c
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Layde Culley yes
6.(c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) Mar 3 1900
8. AGE: Years about 45 Months Days If less than one day ....hrs. ....min.
9. Birthplace Norfolk va (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Jeremiah Williams
13. Birthplace Norfolk va
MOTHER 14. Maiden name Emma Cuffee
15. Birthplace Norfolk va
16. Informant Mr Mary Williams
Address Fruitland
17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 22-1945 (month) (day) (year)
Cemetery or crematory Mt Olive
Location Fruitland
18. Funeral director James H Stewart
Address Salisbury Md
19. 11/22, 1945 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 18 1945, at 4:20 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-1 1945, to 11-17 1945
and that I last saw her alive on 11-17 1945
Immediate cause of death Heart Failure — DURATION 6 mo +
Due to Hypertensive Heart disease
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. Purnell M.D. M. D. or other
Address 800 W Main St. Date signed 11-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-2

CERTIFICATE OF DEATH

1146D

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Jesterville, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frederick Marcus Dashiell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	married

B.(b) Name of husband or wife Anna B. Dashiell

B.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 30 - 1883

8. AGE: Years	Months	Days	If less than one day
62	8	15	hrs. min.

9. Birthplace Jesterville, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Alfred Dashiell

13. Birthplace — Md.

MOTHER 14. Maiden name Barrett Hughes

15. Birthplace White Haven, Md.

16. Informant Anna B. Dashiell

Address Jesterville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/18/45 (month) (day) (year)

Cemetery or crematory Nanticoke Cem.

Location near Jesters store

18. Funeral director E. Passwaters

Address Bivalve, Md.

19. Nov. 16 1945 (Date rec'd by registrar) P. Woolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15th 1945 at 5:45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19.. to Nov 15 1945

and that I last saw h.. alive on Nov 8 1945

Immediate cause of death	DURATION
carcinoma prostate	1½ yrs
Due to	
Metastasis Spine	1 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Spurgeon Tn. M.D. M. D. or other

Address Salisbury Date signed Nov 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11467

Reg. Dist. No. 331

1. PLACE OF DEATH:
County: Wicomico
City or town: Quantico
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address (if not in hospital):
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Quantico
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Arlene Dashiell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	—

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 17, 1945

8. AGE: Years: — Months: 2. Days: 23 If less than one day: ..... hrs. ..... min.

9. Birthplace: Quantico, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace —

MOTHER
14. Maiden name: Mary Jackson
15. Birthplace: Quantico Md.

16. Informant: Mary Jackson
Address: Quantico Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 10 1945 (month) (day) (year)
Cemetery or crematory: Quantico Cemetery
Location: Quantico Md.

18. Funeral director: David L. Messick
Address: Delmar, Md.

19. Nov 10 1945 (Date rec'd by registrar) Mrs J M. Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9, 1945, at 9:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7 1945, to Nov 9 1945
and that I last saw h[illegible] alive on Nov 9 1945
Immediate cause of death: Lobar Pneumonia — DURATION: 4 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J Allen Fields M. D. or other
Address: Marion Md. Date signed: 11-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

1146 332 Reg. Diat. No.

1. PLACE OF DEATH:

County Wicomico.

City or town Pawelsville.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Pawelsville.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margie Davis.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(b) Name of husband or wife Lee Davis.

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 25, 1893

8. AGE: Years	Months	Days	If less than one day
52	5	0	...hrs. ...min.

9. Birthplace Pawelsville Wic. Co. Md. (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name Ebenezer Clark.

13. Birthplace Md.

MOTHER 14. Maiden name Eliza Adkins

15. Birthplace Md.

16. Informant Mr. Lee Davis.

Address Pawelsville. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28/45 (month) (day) (year)

Cemetery or crematory St. Johns

Location Pawelsville Md.

18. Funeral director Anna A. Burbage

Address Berlin Md.

19. 11/28 19 45 (Date rec'd by registrar) Lillian T. Dare Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 19 45, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-23-45 19 to 11-25-45 19

and that I last saw her alive on 11-25-45 19

	DURATION
Immediate cause of death Cerebral Hemorrhage.	
Due to Hypertension & Arteriosclerosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Grant R. Lewis M.D. M. D. or other

Address Pocomoke City Md. Date signed 11-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and tersely.

VS A15

Dr. Yeaman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

11469

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: 1123 E Church street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1123 E. Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie Bennett Elmore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Fredrick B. Elmore
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Jan. 6 - 1870

8. AGE: Years	Months	Days	If less than one day
75	10	11	hrs. min.

9. Birthplace Matthew Co. Va.
(Town, county, and state)
10. Usual occupation Home wife
11. Industry or business at Home

FATHER
12. Name George N. Colonna
13. Birthplace Matthew Co. Va.

MOTHER
14. Maiden name Martha Minter
15. Birthplace Matthew Co. Va.

16. Informant Mrs. Fred Lawson
Address Crisfield Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 20-45 (month) (day) (year)
Cemetery or crematory Crisfield Cem.
Location Crisfield Maryland
18. Funeral director Holloway & Walter R. Hillman
Address Salisbury Maryland.

19. 11/20/45 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17th 19 45 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15, 1945 to Nov 17, 1945 and that I last saw h[illegible] alive on Nov 17, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John H. Yeaman M.D.
M. D. or other
Address 228 Camden Ave. Date signed 11/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186)

11470

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury M
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? I Mouth

Hospital, Institution, or street address where death occurred:
P.G. Hospital

How long in hospital or institution? I Mouth

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County: Northampton

City or town: Exmore
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Norris Elzey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie Elzey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 10, 1874

8. AGE: Years	Months	Days	If less than one day
71	8	23	..... hrs. ..... min.

9. Birthplace: Sussex, Co. Del.
(Town, county, and state)

10. Usual occupation: Saleman

11. Industry or business: Road

FATHER
12. Name: James Elzey
13. Birthplace: Wicomico Co. Md

MOTHER
14. Maiden name: Hester Emily Bradley
15. Birthplace: Wicomico Co. Md

16. Informant: Mr Olin Elzey
Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 / 5 / 45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 11/5/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2 19 45 at 345p M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from September 22 19 45 to Nov 2nd 19 45 and that I last saw h.... alive on Nov 2nd 19 45

Immediate cause of death	DURATION
Heart failure	
Fell, down stairs, cut head	
Due to Nervous Depressions.	
Due to Crushed Skull and Laceration of Brain	
Other conditions cuts & Contusions	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home.

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: C. J. Kenny M.D. M. D. or other

Address: 203 W. Church St. Date signed: Nov. 5, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11471

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

Reg. Dist. No. 733

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred: R.D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mt Hermon Road R.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Frederick Flowers Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 30-1943

8. AGE:

Years	Months	Days	If less than one day
2	9	20	hrs. min.

9. Birthplace: R.F.D. Hoyt Salisbury Md
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: James Frederick Flowers
13. Birthplace: Cambridge Md.

MOTHER
14. Maiden name: Thelma Irene Bond
15. Birthplace: Princess Anne Md.

16. Informant: Mr. James F. Flowers
Address: R.D. #1. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Nov. 23-45 (month) (day) (year)
Cemetery or crematory: Presbyterian Cem
Location: Princess Anne Md.

18. Funeral director: Hollowy & Co. Walter R. Holloway
Address: Salisbury Md.

19. 11/23/45 (Date rec'd by registrar) Bessie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20th 1945, at 7 10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 1945, to Nov 20 1945
and that I last saw h... alive on Nov 19 1945

Immediate cause of death	DURATION
Peritonitis	6 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Warrumer M.D.
M. D. or other
Address: Salisbury Md. Date signed: Nov 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

11472

CERTIFICATE OF DEATH

Reg. Diat. No. 4336

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
201 Pine St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. 411 East St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Washington Greer

3.(b) Social Security Number 222-07-1388-A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sallie Agnes Greer
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 7 - 1868

8. AGE: Years 77 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Georgetown, Del.
(Town, county, and state)

10. Usual occupation: Lumberman

11. Industry or business: Lumber

FATHER
12. Name: George Greer
13. Birthplace: Georgetown, Del.

MOTHER
14. Maiden name: Margaret Coffin
15. Birthplace: Sussex County, Del

16. Informant: Harry E. Greer
Address: Delmar, Del

17. Burial (Burial, cremation, or removal, which?) Date thereof 11 - 14 - 45 (month) (day) (year)
Cemetery or ~~crematory~~: St. Alice Methodist
Location: Delmar Del

18. Funeral director: H. E. Hearn & Co
Address: Delmar, Del

19. 11-14-1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11 1945, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1945, to Nov 11 1945
and that I last saw h~~im~~ alive on Nov 11 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Arteriosclerosis & myocarditis	4 yrs
Due to: Chronic Nephritis	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. E. Hudson M. D. or other
Address: Delmar Del Date signed Nov 14 45

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11473

CERTIFICATE OF DEATH

Reg. Dist. No. 7736

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 411 East

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 411 East
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR -----

3. (a) FULL NAME Sarah Agnes Green

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Geo, W. Green

6(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) April 12, 1875

8. AGE: Years	Months	Days	If less than one day
70			____ hrs. ____ min.

9. Birthplace Reading, Pennsylvania
(Town, county, and state)

10. Usual occupation House work

11. Industry or business Home

FATHER 12. Name Samuel Sawyer

FATHER 13. Birthplace Reading, Pa

MOTHER 14. Maiden name Agnes Johnson

MOTHER 15. Birthplace Reading, Pa.

16. Informant George W. Green

Address Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1945 (month) (day) (year)

Cemetery or crematory Mt. Olive Methodist

Location Delmar, Delaware

18. Funeral director H. S. Ingmal Co

Address Delmar, Delaware

19. Nov. 3rd 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1945, to Nov. 1 1945, and that I last saw her alive on Oct. 31 1945.

Immediate cause of death	Coma	DURATION
Due to	Cerebral Hemorrhage	1 week
Due to	Arteriosclerosis & Hypertension	5 yrs.
Other conditions	Epilepsy	40 yrs

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Ingmal M. D. or other

Address Delmar Del Date signed Nov 6 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

11474

★ Reg. Dist. No. 323

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about year

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Virginia County: Penn

City or town: Cascade (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME (Becky) Rebecca Hairston

3.(b) Social Security Number yes - Don't know number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a a	married

6.(b) Name of husband or wife: Thomas Hairston

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 5-29-1906

8. AGE:	Years	Months	Days	If less than one day
	39	5	25	...hrs. ...min.

9. Birthplace: Cascade, Penn. Co. Virginia (Town, county, and state)

10. Usual occupation: Factory

11. Industry or business: Dulaney & Son

FATHER 12. Name: Bard Eanes

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Martha - Eanes

MOTHER 15. Birthplace: Virginia

16. Informant: Mary Elizabeth Hairston

Address: Lake St., Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-29-45 (month) (day) (year)

Cemetery or crematory: Family Cemetery 11-29-45

Location: Cascade, Virginia

18. Funeral director: James F. Stewart

Address: 402 E. Church Street, Sals. Md.

19. 11/27/45 (Date rec'd by registrar) 19.46 Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/24/1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19... to ...19... and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Stab wound of aorta	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 11/24/45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Fruitland Md

Means of injury: Stabbed Injured at work? No

23. SIGNATURE: J.A. Rodman MD Deputy Med Examiner M. D. or other

Address: Salisbury Md Date signed 11/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1147 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Mount Hermon near Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about year

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: near Salisbury R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Ida M Harmon

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	married

6.(b) Name of husband or wife: Ross Harmon Don't know yet

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): about 1884

8. AGE: Years	Months	Days	If less than one day
about 61	—	—	..... hrs. ..... min.

9. Birthplace: near Snowhill md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home duties alone

FATHER
12. Name: Sanders Duffey
13. Birthplace: Snowhill

MOTHER
14. Maiden name: Elizabeth Williams
15. Birthplace: Snowhill md

16. Informant: Ross Harmon

Address: Salisbury md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 2-1945 (month) (day) (year)

Cemetery or crematory: Hanston

Location: Salisbury Md

18. Funeral director: James A Stewart

Address: Salisbury Md

19. 11/29/1945 (Date rec'd by registrar) Abbie E Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27, 1945 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24, 1945, to Nov. 27, 1945 and that I last saw h.er alive on Nov. 24, 1945

Immediate cause of death	DURATION
Broncho pneumonia	1 day
Due to: Bronchitis	Week
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G H Lemby MD M. D. or other

Address: Salisbury Md Date signed 11/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11476

Reg. Dist. No. 393

1. PLACE OF DEATH: Wicomico

County

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 year

Hospital, Institution, or street address where death occurred: 303 Madison street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 303 Madison st (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Goldston Harrington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Era M. Harrington

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Dec. 21-1877

8. AGE: Years	Months	Days	If less than one day
67	10	25	..... hrs. ..... min.

9. Birthplace: Bivalve Maryland (Town, county, and State)

10. Usual occupation: wheelwright

11. Industry or business: Farmer

FATHER — 12. Name: Beauchamp Trist Harrington

FATHER — 13. Birthplace: Bivalve Md.

MOTHER — 14. Maiden name: Adelia Dunn

MOTHER — 15. Birthplace: Bivalve Md.

16. Informant: Mrs. Era M. Harrington

Address: 303 Madison st. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 19-45 (month) (day) (year)

Cemetery or crematory: Bivalve Church Cem

Location: Bivalve Md.

18. Funeral director: Holloway & Co. Walter R. Williams

Address: Salisbury Md.

19. 11/18/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16th 1945 at 11:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1945, to Nov 16 1945

and that I last saw h/m alive on Nov 12 1945

Immediate cause of death	DURATION
Cardio vascular renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hugh A Insley M. D. or other

Address: Salisbury Md Date signed 11-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 29 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11477

★ Reg. Dist. No. 268

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 1 day - 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Deal Island
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Hughes, Charles.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name ~~of husband or~~ wife Aline Hughes

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) [illegible] Not Obtainable

8. AGE:

Years	Months	Days	If less than one day
69	—	—	....hrs. ....min.

9. Birthplace Deal Island Md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Oyster Shucking

FATHER 12. Name John Hughes

13. Birthplace Deal Island Md

MOTHER 14. Maiden name Not Obtainable

15. Birthplace Deal Island Md

16. Informant Wesley Hughes
Address Deal Island Md

17. Burial Date thereof Nov 12 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Deal Island M.E. Colored

Location Deal Island Md

18. Funeral director E. E. Webster & Co
Address Deal Island Md

19. Nov 12 1945 Rosa Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10-45 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-9 1945, to 11-10 1945 and that I last saw h. alive on 11-9 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 hrs
Due to arteriosclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Rademacher M.D.
M. D., or other

Address Salisbury Md Date signed 11/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11478

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 5 months

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? about 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Del. County: Sussex

City or town: Laurel R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Eschol D. James

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virgie James

B.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): Aug. 20 - 1898

8. AGE:

Years	Months	Days	If less than one day
47	3	9	- hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER

12. Name: John D. James

13. Birthplace: Md.

MOTHER

14. Maiden name: Cassie Lewis

15. Birthplace: Md.

16. Informant: Virgie James

Address: Laurel Del. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4 - 45 (month) (day) (year)

Cemetery or crematory: Del. Line Cemetery

Location: Westsville, Del.

18. Funeral director: Harvey Williamson

Address: Federalsburg - Md.

19. 11/30, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 29 - 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945, to Nov 29 1945

and that I last saw h alive on Nov 29 1945

Immediate cause of death	DURATION
Coronary Thrombosis.	
Due to Cirrhosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op. 11/29/45

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. W. Nock M. D. or other

Address: Salisbury Date signed 11/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11479

336

Reg. Dist. No. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, institution, or street address where death occurred: R 710 H 3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No. R 710 H 3 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Paul Revere Soule

3.(b) Social Security Number 718-01-4751

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennie A. Soule

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 22 - 1895

8. AGE: Years 50 | Months 3 | Days 24 | If less than one day: hrs. min.

9. Birthplace: Laurel, Del R 710 (Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: Penn. Railroad Co.

FATHER 12. Name: H. S. Soule

FATHER 13. Birthplace: Laurel, Del R 710

MOTHER 14. Maiden name: Mary Ellen Figgs

MOTHER 15. Birthplace: Delmar, Del R 710

16. Informant: Jennie A. Soule

Address: Delmar, Del.

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof 11-19-45 (month) (day) (year)

Cemetery ~~or crematory~~: M.E. Ohlo Methodist

Location: Delmar Del

18. Funeral director: G. L. Grant Co

Address: Delmar, Del

19. Nov. 19, 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16, 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to Nov 16 1945 and that I last saw h. alive on Nov 16 1945

	DURATION
Immediate cause of death: Acute Cardiac Failure	
Due to: Hodgkins Disease	2 yr.
Due to: Secondary Anaemia	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. H. Finch M. D. or other

Address: Delmar Del Date signed: Nov 17

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11480

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH: Wicomico
County ..... Salisbury
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: P.H. Hosp.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. RD#4 (If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Mary J. McCann

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 7-1940
8. AGE: Years 5 Months 7 Days 14 If less than one day ..... hrs. ..... min.
9. Birthplace: Wilkes Co. N.C. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Walter A. McCann
FATHER 13. Birthplace: Wilkes Co. N.C.
MOTHER 14. Maiden name: Lelia Johnson
MOTHER 15. Birthplace: Wilkes Co. N.C.
16. Informant: Mr. Walter A. McCann
Address: R.D. #4 Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 23-45 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Md.
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.
19. 11/23/1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21st 1945 at 4:50 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16 1945 to Nov 21 1945
and that I last saw her alive on Nov. 21 1945
Immediate cause of death ..... DURATION
Pneumococic Meningitis 5 days
Due to .....
Due to .....
Other conditions Lobar Pneumonia 6 days
(Include pregnancy within 3 months of death)
Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Steve R Mann M. D. or other
Address Salisbury Md Date signed 11/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (572)

CERTIFICATE OF DEATH

Reg. Dist. No. 4 Reg. No. 1148 336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 107 Spruce St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Spruce

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Sloyd McClain

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 25-1945

8. AGE:

Years	Months	Days	If less than one day
		17	____ hrs. ____ min.

9. Birthplace: Salisbury, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Jas. Edward McClain III

13. Birthplace: Wilmington Del.

MOTHER 14. Maiden name: Mary Balsom

15. Birthplace: Delmar, Del.

16. Informant: J. Edward McClain III

Address: Delmar, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12-1945 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Delmar, Del

18. Funeral director: W. S. Mason Co

Address: Delmar, Del

19. 11-12- 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11 1945, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1945, to Nov 11 1945

and that I last saw him alive on Nov 11 1945

Immediate cause of death	DURATION
Acute Cardiac failure	1/2 hour
Due to: Congenital Malformation of heart	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. E. McClain M. D. or other

Address: Delmar Del. Date signed Nov 12/45

11513

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 years
Hospital, Institution, or street address where death occurred: 301 East Division
How long in hospital or institution? V

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 301 East Division
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Robert E. Morris

3.(b) Social Security Number: 715-70-7379

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Bessie C. Morris
8.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Oct. 21, 1888.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57	1	1		

9. Birthplace: Salisbury, Wicomico, Md. (Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business: Manufacturing

FATHER
12. Name: Thomas Morris
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Eliza Williams
15. Birthplace: Wicomico Co., Md.

16. Informant: A. Reuben Morris,
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/7/45. (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md.

18. Funeral director: De Hall Wilson Co.,
Address: Salisbury, Md.

19. 12/6 1945 (Date rec'd by registrar) Lassie A. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7, 1945, at 11.55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——, 19—, to —, 19—
and that I last saw him alive on —, 19—

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Fred R. Adams M. D.
M. D. or other
Address: Salisbury, Md. Date signed 11/23/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

11482

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County Salisbury

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: 411. Smith St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 411. Smith St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Eliza Morrow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1907

8. AGE: Years 38 | Months 8 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Salisbury Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Charles Morrow

13. Birthplace Dunagold Ireland

MOTHER 14. Maiden name Laura Belle Carey

15. Birthplace Shad Point Md.

16. Informant Mrs. Charles Morrow

Address 411. Smith St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16-45 (month) (day) (year)

Cemetery or crematory Shad Point Cem.

Location Shad Point Maryland

18. Funeral director Holloway & Co. Walter R. Holloway

Address Salisbury Md.

19. 11/16/45 Received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 45 at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19.. to Nov 14 19 45 and that I last saw h.. alive on Nov 13 19 45

Immediate cause of death	DURATION
Chronic carditis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wanner M. D. (M. D. or other)

Address Salisbury Md. Date signed 11/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

11483

CERTIFICATE OF DEATH

Reg. Diat. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Don't know

Hospital, Institution, or street address where death occurred: No

How long in hospital or institution? No

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel Route #3
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Thomas Penn

3. (b) Social Security Number: Yes - Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a a	widowed

6.(b) Name of husband or wife: Nannie Penn

Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): About 1890

8. AGE: Years	Months	Days	If less than one day
About 55			hrs. min.

9. Birthplace: Lawrenceville, Brunswick Co. Va.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Same

FATHER 12. Name: Don't know

13. Birthplace " "

MOTHER 14. Maiden name: Don't know

15. Birthplace " "

16. Informant: Coleman Penn

Address: Laurel, Del. Route #3

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 - 12 - 45 (month) (day) (year)

Cemetery or crematory: Public Cemetery

Location: Salisbury Maryland

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury Md.

19. 11/12/45 (Date rec'd by registrar) 19 45 Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Unknown 19 ..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Drowning	sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 11/6/45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?) Wicomico River

Means of injury Unknown Injured at work?

23. SIGNATURE: J. A. Radcliffe M.D. M. D. or other

Address: Salisbury Md. Date signed 11/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 8330 — 114836

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Years

Hospital, institution, or street address where death occurred:
104 East Isabella St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 E. Isabella St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Rebecca Taylor Phillips

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Waller Phillips

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 12, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	20	..... hrs. ..... min.

9. Birthplace: Wicomico, Co. Md.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Cadmus J. Taylor

FATHER — 13. Birthplace: Wicomico Co. Md

MOTHER — 14. Maiden name: Margaret Ellen Cooper

MOTHER — 15. Birthplace: Wicomico, Co. Md

18. Informant: George Edgar Phillips

Address: Box 203 Lewistown, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/5/45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 11/5 (Date rec'd by registrar) 1945 — Hill & Johnson Co. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1, 1945, at 1.30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29, 1945 to Nov. 1, 1945 and that I last saw h.. alive on Oct. 31, 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 hour
Due to: Hypertension	Under
Due to:	
Other conditions: Valvular Heart Disease	Under

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard R. Mann M. D. or other

Address: Salisbury Md. Date signed: 11-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Mr Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Minn

115714

Reg. Dist. No. 233

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Maryland (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Howard Gordon Rifenbark

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emily Rifenbark

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 15th 1869

8. AGE: Years: 76 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Wisconsin (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Farm

FATHER — 12. Name: Isaiah Rifenbark

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Emily Adams

MOTHER — 15. Birthplace: U. S. A.

16. Informant: Mildred Rifenbark

Address: Delmar, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-3-45 (month) (day) (year)

Cemetery or crematory: G. P. C.

Location: Delmar, Del.

18. Funeral director: H. D. Gravel Co

Address: Delmar, Del.

19. 12/7 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30 1945 at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 1945 to Nov. 30 1945

and that I last saw him alive on Nov. 30 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Hypertension	Unknown
Other conditions: Chronic Nephritis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Howard R Mann M. D. or other

Address: Salisbury Md Date signed: 12/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

Dr. Radcliffe

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 42-B

CERTIFICATE OF DEATH

11485

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. Fourth Street

(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Gertrude Robins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	widowed

6.(b) Name of husband or wife Ernest Robins deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			..... hrs. ..... min.

9. Birthplace Salisbury Wicomico Co. Maryland (Town, county, and state)

10. Usual occupation Factory

11. Industry or business

FATHER 12. Name James Pinkett

13. Birthplace Salisbury, Maryland

MOTHER 14. Maiden name Laura Lewis

15. Birthplace Salisbury, Maryland

16. Informant Mrs. Maggie Williams

Address 382 Waters St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/18/45 (month) (day) (year)

Cemetery or crematory Houston Cemetery

Location Salisbury, Maryland.

18. Funeral director James F. Stewart

Address 402 E. Church St. Salisbury, Md.

19. 11/17/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1945 at 6.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1945 to Nov 13 1945 and that I last saw h... alive on Nov 12 1945

Immediate cause of death	DURATION
Adenocarcinoma of uterus	8 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Oct 26-1945 Exploratory Laparotomy

Date of op.

Autopsy results Carcinoma of uterus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE P.A. Radcliffe M.D. M. D. or other

Address Salisbury Md. Date signed 11/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Rademaker

11486

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: P.R.R. Tracks
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: RD. #1 (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Henry Shockley
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Viola Shockley
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): Aug. 18th 1889

8. AGE: Years: 56 Months: 2 Days: 28 If less than one day ... hrs. ... min.

9. Birthplace: Sussex Co. Del. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace: Peter Shockley
MOTHER 14. Maiden name: Selbyville Del.
15. Birthplace:
16. Informant: Mrs. Viola Shockley
Address: RD. #1. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 20-45 (month) (day) (year)
Cemetery or crematory: Fruitland Cem.
Location: Fruitland Md.
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.
19. 11/20, 19 45 (Date rec'd by registrar) Hessie C. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16th 19 45, at ... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... [Medical examiner post mortem]
and that I last saw h... alive on ... 19 ...

Cause	Duration
Immediate cause of death: Fractured skull, crushed chest	Sudden death
Due to: Fractured Rt leg & arm, amputated Left leg	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 11/16/45
Where did injury occur? Fruitland Wicomico Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): RR crossing
Means of injury: car struck by 2 trains Injured at work? No
23. SIGNATURE: J. A. Rademaker MD Deputy Med. Exam. M. D. or other
Address: Salisbury Md. Date signed: 11/18/45

(I) (T)

Dr. Bishop

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 11487

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: Peninsula Gen. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #3 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie Florence Shockley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William S. Shockley
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): May 10 1879

8. AGE: Years	Months	Days	If less than one day
66	6	0	hrs. min.

9. Birthplace: Wico. Co. Md. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home
12. FATHER — Name: John J. Hammond
13. FATHER — Birthplace: Wico. Co. Md
14. MOTHER — Maiden name: Sallie Lank
15. MOTHER — Birthplace: Wico. Co. Md.
16. Informant: Mr. Floyd Shockley
Address: Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12-1945 (month) (day) (year)
Cemetery or crematory: Hammond Cem.
Location: near Mt. Herman P.O. Salisbury Md.
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.
19. 11/12/45 (Date rec'd by registrar) Lassie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10 1945 at 9:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 1945 to Nov 10 1945
and that I last saw h alive on Nov 10 1945

	DURATION
Immediate cause of death: Cerebral hem.	
as a sequence of Hypertension	6 da
Due to: Hypertension	3 yrs
Due to:	
Other conditions: Nephritis Chronic	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: no operation Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R. Bishop M.D. M. D. or other
Address: Salisbury Md. Date signed 11/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

11488

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Weeks

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 4 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Quantico
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Williams Sydney Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lucy V. Smith

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Setp. 17, 1865

8. AGE: Years	Months	Days	If less than one day
80	1	28	...hrs. ...min.

9. Birthplace: Wicomico, Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: William Smith

13. Birthplace: Wicomico, Co. Md

MOTHER — 14. Maiden name: Chara Giles

15. Birthplace: Somerset, Co. Md

16. Informant: W. Paul Smith

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 / 16 /45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 11/16, 1945 (Date rec'd by registrar) Larrie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14, 1945, at 6p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 1945 to Nov 14 1945

and that I last saw h... alive on Nov 14 1945

Immediate cause of death	DURATION
Uraemia	6 days
Due to	
Due to	
Other conditions Hypertension	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other

Address: Salisbury Date signed: Nov. 16 1945

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1148

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Woodland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wic.

City or town: Salis.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Woodland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Howard James Stanford Jr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	infant

B.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): November 10, 1945

8. AGE: Years: — Months: — Days: 6 — If less than one day: hrs. min.

9. Birthplace: Salis., Wic., Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Howard James Stanford
13. Birthplace: Princess Anne, Md.

MOTHER
14. Maiden name: Eleanor Barkley
15. Birthplace: Salisbury, Md.

16. Informant: Howard James Stanford
Address: Woodland, Md. Pine St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/16/45 (month) (day) (year)

Cemetery or crematory: Family
Location: Camden, Md.

18. Funeral director: Howard James Stanford
Address: acting Pine St., Woodland, Md.

19. 11/15 1945 (Date received by registrar) Carrie C. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16th 1945 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
Medical & Examiners Report
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Premature Infant	7 mos.
Due to: Natural causes	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Chas. T. Fenton M.D.
Medical & Examiners M. D. or other
Address: Salisbury, Md. Date signed: 11-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Hamm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

11494

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 years
Hospital, institution, or street address where death occurred: 109 E. William St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 E. William St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Pansy Eloise Taylor

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: J. Ryland Taylor
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): Dec. 11 1881
8. AGE: Years 63 Months 11 Days 1 If less than one day hrs. min.
9. Birthplace: Worcester Co. Md. (Town, county, and state)
10. Usual occupation: Home wife at Home
11. Industry or business:
FATHER 12. Name: William J. Ennis
13. Birthplace: Worcester Co. Md.
MOTHER 14. Maiden name: Mary A. Fleming
15. Birthplace: Worcester Co. Md.
16. Informant: Mr. J. Ryland Taylor
Address: 109 E. William St. Salisbury Md
17. Burial
(Burial, cremation, or removal. Which?) Date thereof Nov. 14-45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md.
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.
19. 11/14/45 1945 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 & 1945 at 11 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Nov. 12 1945 and that I last saw her alive on Nov. 12 1945

	DURATION
Immediate cause of death: Pulmonary Edema, Acute	
Due to: Rheumatic Heart Disease	
Due to: Mitral Stenosis + Mitral Insufficiency	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury Injured at work?
23. SIGNATURE J. Fineas Hansen M.D.
M. D. or other
Address Salisbury, Md. Date signed 11/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11491

Reg. Dist. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Near Delmar Md Side
(If outside city or towo limits, write RURAL and give nearest towo)

How long in above place of death? about 4 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Delmar Md Side R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No. no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME Jim Piney

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a. a.	married

6.(b) Name of husband or wife: Leah Piney

Dead 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) about 1885

8. AGE: Years	Months	Days	If less than one day
about 60	—	—	....hrs. ....min.

9. Birthplace Del (Town, county, and state)

10. Usual occupation Lumber

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Edward Snead

Address Allomal

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 24-1945 (month) (day) (year)

Cemetery or crematory Allomal va

Location Allomal va

18. Funeral director G. Edgar Thomas

Address Allomal va.

19. 11/29/45 (Date rec'd by registrar) Isaac E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1945 at 5-9 a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.... and that I last saw h.... alive on ..... 19.... Medical Examiner ex officio

Immediate cause of death	DURATION
Cerebral Thrombosis	sudden death
Due to	
Due to	
Other conditions Previous apoplexy	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. A. Rademaker M.D. Deputy Medical Examiner

Address Salisbury Md M. D. or other

Date signed 11/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11492

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

Reg. Dist. No. 338

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 Years

Hospital, institution, or street address where death occurred:
Mt. Mermon Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural 3
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elmer H. Venables

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Ronie B. Venables

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Sept, 27, 1884

8. AGE: Years: 61 Months: I Days: 8 If less than one day: ...hrs. ...min.

9. Birthplace: Mardela Spring, Wicomico, Co. Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: William Rush Venables

FATHER
12. Name: Mardela Spring, Md
13. Birthplace:

MOTHER
14. Maiden name: Nancy Bradley
15. Birthplace: Mardela Spring, Md

16. Informant: Mrs Elmer H. Venables
Address: Salisbury Md R. D. 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 (month) /6 (day) /45 (year)

Cemetery or crematory: Walston Family Cemetery

Location: Mt. Hermon Salisbury, MD

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 11/6/45 (Date rec'd by registrar) Harris E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1945, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1945, to Nov 4 1945, and that I last saw h[illegible] alive on Nov 4 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Arteriosclerosis	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Geo. E. Hurley M. D. or other

Address: Salisbury Md Date signed: 11-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

11493

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico.
City or town Salisbury Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Peninsula General Hospital.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Caroline
City or town Federalsburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. F. D.
(If rural, give LOCATION)
2.(a) If veteran, name war no ✓

3.(a) FULL NAME Venable, Mrs Nettie M.

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Mr. Edward Venable
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 17, 1880

8. AGE: Years 66 Months 6 Days 16 If less than one day ..... hrs. ..... min.

9. Birthplace Federalsburg Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business "

FATHER 12. Name Greenbury Nichols
13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Noble
15. Birthplace Md.

16. Informant Roy Venable
Address Federalsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1945 (month) (day) (year)

Cemetery or crematory Laytonia
Location Near Federalsburg

18. Funeral director Harvey Williams
Address Federalsburg, Md.

19. 11/6/45 (Date rec'd by registrar) 19 45 Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 19 45 at 12:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 19 45, to Nov 3 19 45
and that I last saw h[illegible] alive on Nov 2 19 45

Immediate cause of death	DURATION
Hemolyzed Carcinomatosis of abdomen	3 mos.
Due to Primary in sigmoid colon Cancer	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Hemolyzed Carcinoma of abdomen Date of op. 10/26/45

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L A Rademaker M.D
M. D. or other
Address Salisbury Md. Date signed 11/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11494

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1260

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 Years

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 6 Weeks 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. Lakeside, East Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nannie Todd Wailes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct, I, 1860

8. AGE: Years	Months	Days	If less than one day
85	I	I6	..... hrs. ..... min.

9. Birthplace Salisbury, Wicimico, Md
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Ebenezer Wailes
13. Birthplace Wicomico, Co, Md

MOTHER
14. Maiden name Annie Todd
15. Birthplace Wicomico, Co, Md

16. Informant Miss Laura Wiales

Address Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/20/45 (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Salisbury, Md

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 11/20 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1945 805A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/2 1945 to 11/17 1945 and that I last saw h[illegible] alive on 11/17 1945

Immediate cause of death	DURATION
Fracture of Hip	
Due to Fall on floor.	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/2/45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fall on floor. Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Salisbury, Md Date signed 11/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15